



Dear Community Partner,

Your client, _____, has requested an exemption from required work-related activities associated with their application for/receipt of Supplemental Nutrition Assistance Program (SNAP).

Your client has a 3-month SNAP time limit because they are an ABAWD. According to our records they are:

- Between the ages of 18-49
- Living in a SNAP household where no one is under age 18
- Not receiving disability payments
- Not pregnant
- Not working at least 80 hours a month
- Not participating in a SNAP E&T program or WIOA funded program
- Living in: Barrington, Cumberland, Exeter, Glocester, Jamestown, Lincoln, Little Compton, Narragansett, Newport, North Kingstown, North Smithfield, Richmond, Warwick.
- Or (effective September 1, 2019) living in the following additional cities and towns: Bristol, Burrillville, Coventry, Cranston, East Greenwich, Foster, Hopkinton, Middletown, Portsmouth, Smithfield, South Kingstown, Tiverton, West Greenwich

If you believe the above information to be incorrect, please assist your client with reporting that to DHS.

If the above information is accurate, your client may be exempt from the ABAWD work requirement and able to maintain benefits beyond 3 months, if they are physically, mentally, or emotionally unfit for work.

Your familiarity with the SNAP applicant may help us to determine whether they meet the unfit for work criteria.

- ❖ Does your client have multiple weekly medical (including counseling) appointments making it difficult for them to get or maintain employment?
 Yes No verification: Note, on official letterhead, from health care professional/health center
- ❖ Does your client have regular meeting and obligations as part of their engagement with your agency that hinders their ability to get or maintain employment?
 Yes No verification: Note, on agency letterhead, indicating frequency of commitment
- ❖ Does your client struggle with any of the following making it difficult for them to get or maintain employment?
 ___ making eye contact ___ talking to people ___ organization of time
 ___ access to bathing/hygiene ___ no safe place to keep belongings

Is there anything you think we should know about your client to help us determine their ability to find and maintain employment?

Name of person completing this form _____ Date _____

Agency / Title _____ Phone _____

How to get this form to DHS:

Upload it to a Customer Portal account at www.healthyrhode.ri.gov

Mail it to: State of RI, PO Box 8709, Cranston, RI 02920-8787

Bring it to a DHS field office in Newport, Pawtucket, Providence, Wakefield, Warwick, or Woonsocket

If your client is applying or recertifying at this time, they may submit it with their DHS forms.